MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Mailing: PO Box 5008, Madison, WI 53705 • Phone: 1-800-356-9601 Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717 Return application to:

National Insurance Services
300 North Corporate Drive, Suite 300
Brookfield, WI 53045

Attention: Billing Department

Evidence of Insurability

(A separate form must be completed for each person seeking coverage.)

Check appropriate box(es):	Reason for Applying: ☐ New Hire ☐ Late Enrollee						
□ Life/AD&D	☐ Supp. Life:\$	☐ Increase in Coverage amount ☐ Reinstatement					
☐ Long Term Disability	□ AD&D:\$	☐ Adding Dependent(s) ☐ Applying for coverage over GI					
☐ Short Term Disability	□ AD&D:\$	☐ Other:	117 6	C			
		LICANT INF	ORMATION				
Applicant's Name: Last, First	, MI		Sex:	Age:	Date of Birth:		
			\Box M \Box F		/ /		
Height: Weight:			Applicant's Social Sec	dy Enrolled?			
			DYes DNo				
Applicant's Home Address: ((Street, City, State, Zip)			Applicant's Day			
	(, <u>-</u> <u>-</u> , <u>F</u>)			()			
Applicant's Current Physici	an's Name:		Date Last Visited: Reason for Visit:				
inplicant's current injure	di b i (diiio)		/ / Keason for visit.				
Physician's Address: (Street,	City State Zin)		, ,	Physician's Pho	ne No		
i hysician's Address. (Succe,	City, State, Zip)			i nysician s i noi	ic ivo.		
Employee Member Name: (i	f different than Applicant)		Employee's Job Title:				
Employee Member Name. (I	different than Applicant)		Employee 8 300 Title.				
Employee's Date of Hire:	No of Ho	una Employaa	Works Per Week:	Employage /g	Annual Salary:		
Employee's Date of Hire:	10.01110	urs Employee	WOIRS FEI WEEK:	\$	Aimuai Saiary:		
TO 1 N	T	11- A J.J	(Ct				
Employer Name:	EII	ipioyer's Adar	ess: (Street, City, State, Z	1p)			
	_		EGETANIC				
		IEALTH QU					
	s or No, circle all applica			d give details be	ow.		
I. Are you currently pregnar	nt? ☐ Yes ☐ No If "Yo	es", what is you	ır expected due date:				
II. In the past 5 years have y	ou been diagnosed or tre	ated by a medi	cal professional for any	of the following c	onditions?		
A. HEART			D. PAIN & DISCOME	FORT			
1. Heart ailment?		□ Yes □ No	1. Arthritis, bursitis or g				
2. Chest pain, angina or shortn	ess of breath?			ent back pain or slipped disk?			
3. Irregular heart beat or heart	☐ Yes ☐ No		der of the back, neck or spine?				
4. Rheumatic fever?	☐ Yes ☐ No		f the muscles, bones or joints?				
5. Disease or abnormality of he		5. Temporomandibular joint (TMJ) Disorder?					
vessels?		□ Yes □ No					
6. Stress test; electrocardiogram	□ Yes □ No	6. Recurrent abdominal pain? ☐ Yes ☐ N					
B. TUMORS/CYSTS	E. OTHER						
1. Cancer of any type?			LE. OTHER				
		□ Yes □ No		ler or epilepsy?	□ Yes □ No		
2. Tumors, cysts, or polyps?		☐ Yes ☐ No	1. Stroke, seizure disord	1 1 7	☐ Yes ☐ No		
2. Tumors, cysts, or polyps? C. BLOOD AND URINE		☐ Yes ☐ No ☐ Yes ☐ No	 Stroke, seizure disord Migraine or persisten 	t headaches?	□ Yes □ No		
C. BLOOD AND URINE	or hypertension?	□ Yes □ No	 Stroke, seizure disord Migraine or persisten Nervous/mental disord 	t headaches? der, depression or	☐ Yes ☐ No anxiety? ☐ Yes ☐ No		
C. BLOOD AND URINE 1. High or low blood pressure			 Stroke, seizure disord Migraine or persisten Nervous/mental disor Dizziness or paralysi 	t headaches? der, depression or s?	anxiety?		
C. BLOOD AND URINE 1. High or low blood pressure 2. Venereal disease, syphilis, g		☐ Yes ☐ No	 Stroke, seizure disord Migraine or persisten Nervous/mental disor Dizziness or paralysi Asthma, emphysema, 	t headaches? der, depression or s?	□ Yes □ No anxiety? □ Yes □ No □ Yes □ No		
C. BLOOD AND URINE 1. High or low blood pressure 2. Venereal disease, syphilis, g genital herpes?	conorrhea, genital warts or	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	 Stroke, seizure disord Migraine or persisten Nervous/mental disor Dizziness or paralysi Asthma, emphysema, disorder? 	t headaches? der, depression or s? breathing or lung	□ Yes □ No anxiety? □ Yes □ No □ Yes □ No □ Yes □ No		
C. BLOOD AND URINE 1. High or low blood pressure 2. Venereal disease, syphilis, genital herpes? 3. Disorder of kidneys or blad	onorrhea, genital warts or der or kidney stones?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	 Stroke, seizure disord Migraine or persisten Nervous/mental disor Dizziness or paralysi Asthma, emphysema, disorder? Indigestion, ulcers or 	t headaches? der, depression or s? breathing or lung	□ Yes □ No anxiety? □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No		
C. BLOOD AND URINE 1. High or low blood pressure 2. Venereal disease, syphilis, g genital herpes? 3. Disorder of kidneys or blad 4. Diabetes, high or low blood	onorrhea, genital warts or der or kidney stones? sugar?	☐ Yes ☐ No ☐ Yes ☐ No	 Stroke, seizure disord Migraine or persisten Nervous/mental disor Dizziness or paralysi Asthma, emphysema, disorder? Indigestion, ulcers or Chronic fatigue? 	t headaches? der, depression or s? breathing or lung rirritable bowel?	□ Yes □ No anxiety? □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No		
C. BLOOD AND URINE 1. High or low blood pressure 2. Venereal disease, syphilis, genital herpes? 3. Disorder of kidneys or blad	onorrhea, genital warts or der or kidney stones? sugar?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	 Stroke, seizure disord Migraine or persisten Nervous/mental disor Dizziness or paralysi Asthma, emphysema, disorder? Indigestion, ulcers or Chronic fatigue? Acquired Immune Description 	t headaches? der, depression or s? breathing or lung rirritable bowel?			
C. BLOOD AND URINE 1. High or low blood pressure 2. Venereal disease, syphilis, g genital herpes? 3. Disorder of kidneys or blad 4. Diabetes, high or low blood	der or kidney stones? sugar? ine?	☐ Yes ☐ No ☐ Yes ☐ No	 Stroke, seizure disord Migraine or persisten Nervous/mental disor Dizziness or paralysi Asthma, emphysema, disorder? Indigestion, ulcers or Chronic fatigue? 	t headaches? der, depression or s? breathing or lung rirritable bowel? eficiency Syndror	□ Yes □ No anxiety? □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No		

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HEALTH QUESTIONS continued								
Check all applicable disorders and give details below. III. In the past 5 years have you been diagnosed or treated by a medical professional for a disease or disorder of the:								
A. Brain or nervo	•	cen diagnosed of th	-	D. Prostate, ovaries or uterus?	□ Yes □ No			
B. Eyes, ears, nos	•		□ Yes □ No	E. Stomach, intestine, gallbladder or	liver?	☐ Yes ☐ No		
C. Skin or lymph			☐ Yes ☐ No	F. Thyroid, spleen or any gland?	nver.	☐ Yes ☐ No		
, ,	years, have you:		_ 105	1. Infloid, spiceri of any grand.		= 105 = 110		
		e use of alcohol or		C. Been treated or evaluated in a ho	snital or	ĺ		
A. Sought or received advice for the use of alcohol or other chemicals or drugs?		\square Yes \square No	medical or psychiatric facility?		□ Yes □ No			
	undergone any surg	gery?	□ Yes □ No	D. Sustained illness requiring medical care or				
		•		hospitalization?		□ Yes □ No		
V. In the last 12	months, have you	ı used tobacco of ar	ny kind? □ Yes □	No				
VI. Please list al	ll prescribed and	non-prescribed me	edications you c	urrently take:				
		_	_					
If you answered				explain below. (Please use another she				
Dates	Condi	itions	Do	ctor Names and Addresses	I I	Results		
<u> </u>								
	۸CI	NOWI FDCFM	FNTS AUTH	ORIZATIONS & SIGNATURE				
I understand all statements and answers I have given are to be relied upon and form the basis of any coverage issued to me and/or my dependents under the Group Policy. I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Madison National Life Insurance Company, Inc., of any change in my medical condition while my enrollment is pending. I agree that if my enrollment is approved by Madison National Life Insurance Company, Inc., the effective date of any coverage will be determined in accordance with the terms of the Group Policy, including any Actively at Work requirement. I acknowledge this Evidence of Insurability form (when approved), the Group Policy, Certificate of Insurance, and any endorsement, amendment or rider hereto, are part of the insurance coverage(s) applied for. I understand that no insurance agent or broker, or persons other than officers of Madison National Life Insurance Company, Inc., can modify, waive or change this form, nor bind coverage or guarantee approval of this form. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, Veterans Administration Facility, or other medically related facility, state or local government agency, insurance or reinsurance company, consumer reporting agency, or employer, to give to Madison National Life Insurance Company, Inc., its legal representative or its reinsurers any and all such information to use for underwriting insurance. I agree that this authorization, in connection with this form, shall be valid for 24 months from my signature date and that I have the right to revoke this authorization at any time. I agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request. WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or kn								
oenems.								
Applicant's Sign	nature			Date				
D 4/6	G: 4 C		1 10	D. (
Parent/Guardian Signature (for Dependent enrollees under age 18) Date								
FOR INSURER USE ONLY: Decision: Decision: De								

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Helpful Hints When Filling Out Your "Evidence of Insurability" Application

In order to process your request for Life and or Disability Insurance you are required to complete the following application. Please use **blue or black ink** and make sure all questions are answered completely and fully. An incomplete document with missed answers will result in the application being returned to you and a delay in the processing of your request. If you are requesting coverage for family members, complete an additional form for each person.

								Please be sure to	o)
MADISON NATIONAL LIFE INSLID	NCE COMP.	ANY INC)		HEALTH OUEST	TIONS continued	give the actual r	name
MADISON NATIONAL LIFE INSURANCE COMPANY, INC. Mailing: PO Box 5008, Madison, WI 53705 • Phone: 1-800-356-9601						Check all applicable disor		of the medicatio	
Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717							edical professional for a disease or dis		
					A. Brain or nervous system?		o D. Prostate, ovaries or uterus?	you are taking, r	not
Evidence of Insurability (A separate form must be completed for each person seeking coverage.)					B. Eyes, ears, nose or throat? C. Skin or lymph nodes?	□ Yes □ N □ Yes □ N		just what the dru	
					IV. In the past 5 years, have you:		1. Thyroid, spicen of any giand.		by is
· •				, l	A. Sought or received advice the us	se of alcohol or other	C. Been treated or evaluated in a	used for.	
Check appropriate box(es): ☐ Life: \$ ☐ Life/AD&D ☐ Supp. Li		-	New Hire ☐ Late Enrollee		chemicals or drugs? B. Scheduled or undergone any sur	gery?			
Long Term Disability	ite your he	eight in dent(s)	Applying for coverage over GI		B. Scheduled of undergone any sur	gery:	hospitalization?	Take care to spe	7
	t and inch			_	V. In the last 12 months, have you	u used tobacco of any kind? □ Ye	s 🗆 No		,11
Applicant's Name: Last, First, MI	i dila ilici	Age:	Date of Birth:	•	VI. Please list all prescribed and	non-prescribed medications yo	u currently taker	the medication	
Appreciate 5 / values Edus, 7 ilos, 7/1		□M □F	/ / /				+ ´	correctly.	
Height: Weight:		Applicant's Social Security N		1			1	L Corrocny.)
Applicant's Home Address: (Street, City, State, Zip)	Applic	☐ Yes ☐ No cant's Daytime Phone No.	-	If you answered "Ves" to any He	alth Questions in this form, plea	se explain below. (Please use another sh	neet of paper if necessary)	
		())		Dates Cond		Doctor Names and Addresses	Results	
Applicant's Current Physician's Name:		Date Last Visited: R	eason for Visit:					******	1
Physician's Address: (Street, City, State, Zip)		/ / / Physic	cian's Phone No.						
Luysician s Address. (Succe, City, State, Zip)		Filysic	an s i none ivo.						
Employee Member Name: (if different than Applica	nt)	Employee's Job Title:					CHODIZATIONS & SIGNATURE		
Employee's Date of Hire: No. of	Hours Employee	Works Per Week: En	nployee's Annual Salary:		ou answered YES to ar		on and form the basis of any coverage	issued to me and/or my	
Employer Name:	Employer's Addr	ess: (Street, City, State, Zip)		- Que	estions, complete this	explanation	s or failure to report information which enial of payment of a claim. I agree to		
Employer Name.	Employer system	essi (ouces, eny, ouic, zip)			ion. The date should l		my enrollment is pending. I agree that	if my enrollment is approved	
						be life dule of	of any coverage will be determined in	accordance with the terms of	
Check Yes or No, circle all app	HEALTH QUI		dataile balow	the \	original diagnosis.				
I. Are you currently pregnant? Yes No If			details below.		amendment or rider hereto, are nar	rt of the insurance coverage(s) and	he Group Policy, Certificate of Insuran blied for. I understand that no insurance		
II. In the past 5 years have you been diagnosed or			ollowing conditions?	1 1	other than officers of Madison Nat		nc., can modify, waive or change this fo		
A. HEART		D. PAIN & DISCOMFORT] [guarantee approval of this form.				
1. Heart ailment?	□ Yes □ No	Arthritis, bursitis or gout?	□ Yes □ N		I hereby authorize any licensed phy	ysician, medical practitioner, hospi	tal, clinic, Veterans Administration Faci	lity, or other medically related	
Chest pain, angina or shortness of breath? Irregular heart beat or heart murmur?	☐ Yes ☐ No	 Recurrent back pain or slipp Disorder of the back, neck or 			facility, state or local government a	igency, insurance or reinsurance co	mpany, Medical Information Bureau, In	nc., consumer reporting	
Rheumatic fever?	□ Yes □ No	Disorder of the muscles, bor					npany, Inc., its legal representative or its rization, in connection with this form, sh		
5. Disease or abnormality of heart muscle, nerves or		5. Temporomandibular joint (T		1 1			rization, in connection with this form, sn at any time. I agree that a photocopy o		
vessels? 6. Stress test; electrocardiogram or echocardiogram?	☐ Yes ☐ No	Recurrent abdominal pain?	□ Yes □ N	- 1	valid as the original and I understar	nd that a copy is available to me up	on request. I have read the separate not		
B. TUMORS/CYSTS	LIES LINO	E. OTHER	□ Yes □ N		pertaining to the Medical Informati			4 lil	
1. Cancer of any type?	□ Yes □ No	1. Stroke, seizure, disorder or e] [ent claim for payment of a loss or benefi nd subject to fines, confinement in priso		
2. Tumors, cysts, or polyps?	☐ Yes ☐ No	Migraine or persistent heada			benefits.	nay ov gamy or a crime a	in priso	,	
C. BLOOD AND URINE	DV DN	Nervous/mental disorder, dep Discripage or possibility		- 1					
 High or low blood pressure or hypertension? Venereal disease, syphilis, gonorrhea, genital warts 	☐ Yes ☐ No	 Dizziness or paralysis? Asthma, emphysema, breathi 	ng or lung				D		
genital herpes?	□ Yes □ No	disorder?	Yes N		Applicant's C'		Kead all acknow	vledgements and	
Disorder of kidneys or bladder or kidney stones?	☐ Yes ☐ No	Indigestion, ulcers or irritab] [Applicant's Signature		+ authorizations of	tatements. Sign an	d data
4. Diabetes, high or low blood sugar?	☐ Yes ☐ No	7. Chronic fatigue?	□ Yes □ N						
5. Protein, blood or sugar in urine?	□ Yes □ No	8. Acquired Immune Deficience					the application.	Please remember	– each
6. Night sweats, persistent swollen glands or diarrhea	?	(AIDS)? 9. Aids Related Complex (ARC	☐ Yes ☐ N C)? ☐ Yes ☐ N		Parent/Guardian Signature (for I	Dependent enrollees under age 18)			
or regard or varie, persistent errollen glands of diaffiled	. 103 5140	10. Human Immunodeficiency			FOR INSURER USE ONLY:	Decision: ☐ Approved ☐ Postponed		d sign his or her a	
					Hadamatada Ciasatura		however the em	ployee needs to si	gn on
Please answer each and					ease be sure to contac			or dependent child	
Avoid drawing a contin				_	urance Services with a	,			
Also, please make sure	your chec	ck mark clearly fo	alls within a yes		your health while you				
or no box.					nding. Failure to do s				
				l the	e rescission of insuran	ce and/or denial			

If you have any questions when you complete this form please feel free to contact Medical Underwriting at National Insurance Services at 800-627-3660 between the hours of 8 am and 5 pm central time, Monday through Friday.

of payment of a claim.